

STATE FAIR RELIEF FUND  
CLAIM FORM  
DEADLINE FOR SUBMISSION OF THIS FORM IS NOVEMBER 14, 2011

**SIGNATURE BY CLAIMANT OR REPRESENTATIVE AND INFORMATION CONTAINED ON THIS FORM DOES NOT CONSTITUTE A WAIVER OF ANY LEGAL RIGHT.**

To assist us in responding to your claim as soon as possible, please help us by completing the information requested in the form below. Any information contained within this form will be considered confidential.

If hand written, please print clearly.

**SECTION 1: CLAIMANT INFORMATION**

Full Legal Name: \_\_\_\_\_

Social Security Number: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

Street Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Telephone (Day) \_\_\_\_\_ (Evening) \_\_\_\_\_ Email: \_\_\_\_\_

**SECTION 2: REPRESENTATIVE INFORMATION**

If the claimant is a minor, incompetent adult, or is deceased, please provide the name, address and telephone number of the person making this claim for the minor or the estate:

Full Legal Name: \_\_\_\_\_

Relationship to claimant:

\_\_\_\_\_

Social Security Number: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

Street Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Telephone (Day) \_\_\_\_\_ (Evening) \_\_\_\_\_ Email: \_\_\_\_\_

### SECTION 3: INFORMATION REGARDING THE CLAIMANT'S PHYSICAL INJURIES

Did the claimant die as a result of the injuries sustained in the accident of August 13, 2011?

☐ Yes      ☐ No

Was the claimant admitted to the hospital as a result of the injuries sustained on August 13, 2011?

☐ Yes      ☐ No

Number of days admitted to the hospital overnight from injuries sustained during the period August 13, 2011 to October 2, 2011.

### SECTION 4: MEDICAL DOCUMENTATION

Please attach hospital bills, records or other documentation to verify length of time admitted to the hospital. If you do not have the documentation, please explain:

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### SECTION 5: METHOD OF PAYMENT

☐ Please make payment to:

☐ claimant                      or                      ☐ parent or  
representative

*Indiana law requires that payments are received via electronic transfer of funds unless a waiver is granted by the Auditor of the State. See, IC 4-13-2-14.8.*

☐ Please make a Direct Deposit/Electronic Funds Transfer into the account shown below. Please attach voided check if possible. This will greatly reduce chance of error.

Account No.: \_\_\_\_\_

ABA Routing No.: \_\_\_\_\_

Name of Financial Institution: \_\_\_\_\_

Name of Bank Contact: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Telephone No.: \_\_\_\_\_

Signature of account holder authorizing transfer: \_\_\_\_\_

**OR**

☐ I request a waiver from electronic transfer requirements.

Please mail check made payable to:

\_\_\_\_\_

☐ claimant

or  
representative

☐ parent or

I verify under the penalties of perjury that the information contained in this CLAIM FORM, and attached to it, is true and accurate and further understand that this form does not constitute a waiver of any legal right. **Claim form must be signed in the presence of a Notary Public.**

\_\_\_\_\_  
Signed

\_\_\_\_\_  
Signed

Dated: \_\_\_\_\_

\_\_\_\_\_  
Representative Capacity

**Mail to:**

Indiana State Fair Commission  
Administrative Building  
Attn: Claims Processor  
1202 East 38th Street  
Indianapolis, Indiana 46205  
Toll Free: 1-855-222-0003  
[www.in.gov/sfc](http://www.in.gov/sfc)

\*The Claims Processor must receive a claim form with original signatures.

COUNTY OF \_\_\_\_\_ )

On the \_\_\_\_ day of \_\_\_\_\_, 20\_\_\_\_,  
personally appeared before me, a Notary Public, in and for said  
County and State, \_\_\_\_\_, known to be the  
person(s) named herein, stated to me that (he/she/they) had/have  
read for foregoing and that the facts and representations  
contained herein are true and correct to the best of his/her/their  
knowledge and belief, and further he/she/they acknowledged the  
execution of the foregoing as his/her/their free and voluntary act  
and deed.

IN WITNESS WHEREOF, I have hereunto set my hand and Notarial Seal, this \_\_\_\_ day of \_\_\_\_\_, 20\_\_.

NOTARY PUBLIC

PRINTED

My Commission Expires:  
County

A resident of \_\_\_\_\_